

§ 155.1040

Exchange under §156.470 of this subchapter, to ensure that such allocations meet the standards set forth in §156.470(c) and (d).

(2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or stand-alone dental plan offered, or intended to be offered in the individual market on the Exchange.

(3) The Exchange must collect annually any estimates and supporting documentation that a QHP issuer submits to receive advance payments of certain cost-sharing reductions, under §156.430(a) of this subchapter, and submit, in the manner and timeframe established by HHS, the estimates and supporting documentation to HHS for review.

(4) HHS may use the information provided to HHS by the Exchange under this section for the approval of the estimates that an issuer submits for advance payments of cost-sharing reductions, as described in §156.430 of this subchapter, and the oversight of the advance payments of cost-sharing reductions and premium tax credits programs.

(c) *Multi-State plans.* The U.S. Office of Personnel Management will ensure compliance with the standards referenced in this section for multi-State plans, as defined in §155.1000(a).

[78 FR 15534, Mar. 11, 2013]

§ 155.1040 Transparency in coverage.

(a) *General requirement.* The Exchange must collect information relating to coverage transparency as described in §156.220 of this subtitle from QHP issuers, and from multi-State plans in a time and manner determined by the U.S. Office of Personnel Management.

(b) *Use of plain language.* The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

(c) *Transparency of cost-sharing information.* The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an

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individual as required by §156.220(d) of this subtitle.

§ 155.1045 Accreditation timeline.

(a) *Timeline.* The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by §156.275 of this subchapter, except for multi-state plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-state plans.

(b) *Federally-facilitated Exchange.* The accreditation timeline used in federally-facilitated Exchanges follows:

(1) During certification for an issuer's initial year of QHP certification (for example, in 2013 for the 2014 coverage year), a QHP issuer without existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is applying to offer coverage must have scheduled or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity.

(2) Prior to a QHP issuer's second year and third year of QHP certification (for example, in 2014 for the 2015 coverage year and 2015 for the 2016 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products, or a QHP issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.

(3) Prior to the QHP issuer's fourth year of QHP certification and in every subsequent year of certification (for example, in 2016 for the 2017 coverage year and forward), a QHP issuer must be accredited in accordance with §156.275 of this subchapter.

[78 FR 12865, Feb. 25, 2013]